

Medical Release:

Patient's Name: _____ Physician's Name: _____

Travel Date: _____ returning _____

Maximum mass flow rate of liters per minute required at 8,000 feet altitude: _____ LPM
 (Options include .50, 1, 1.5, 2, 2.5, 3, 4, 5, or 6 LPM)

The maximum amount of oxygen required per hour (above number x 60): _____ LPH

Valid for travel: ___ / ___ / ___ to ___ / ___ / ___

(____) Please check this box if the patient/passenger may return up to 7 days beyond actual travel date if delay is for non-medical reasons.

Customer requires (check one): Medical Attendant _____ Non-Medical Attendant _____

No Attendant _____

Is oxygen required at sea level?: _____

I certify that the above patient is under my care, and in my opinion, may travel onboard a commercial aircraft without the likelihood of medical risk to their health and/or physical condition. This patient is capable of completing the flight safely without extraordinary medical assistance even if the flight is of greater length than scheduled, terminates at a point other than the expected destination or involves irregular operations.

I also certify that if the customer requires continuous oxygen in flight (60 min/per hour), that this customer will not require Copa Airlines to provide oxygen at the originating city, between connecting flights or at the customer's final destination.

Physician's Signature: _____ DEA: _____

Address: _____

Office Phone Number: _____ Date: _____

For Copa Airlines Use

	DEPARTURE		RETURN		TOTAL
	I LEG	II LEG	I LEG	II LEG	
Trip					
Flight Time					
Bottles Qty					